Virginia Department of Health Division of Tuberculosis (TB) Control
TB Risk Assessment Form

Date **LHD** **PHN Name** **PHN Phone #**

Patient Information

Name (l, f)_____ DOB____/____/____ Sex_____ Race_____

Address_____ Phone #_____ SS # OR Alien #_____

Country of Birth_____ Year Arrived in US_____ Hx of Prior BCG ☐ No ☐ Yes Year_____

Allergies_____ Pregnant? ☐ No ☐ Yes → EDD____/____/____ or LMP____/____/____

Prior Mantoux Tuberculin Skin Test Result: ☐ No ☐ Yes → Date ____/____/____ Results in Induration _____mm

TB-Like Symptoms: ☐ None

☐ Fever ☐ Fatigue ☐ Wt. Loss
☐ Chills ☐ Nights Sweats ☐ Hemoptysis
☐ Anorexia ☐ Cough →↓
Productive? ☐ No ☐ Yes

HIV Status: ☐ Pending Test Date ____/____/____

☐ Positive ☐ Indeterminate ☐ Declined Testing
☐ Negative ☐ Denies Risk(s)

If HIV (+), is patient on protease inhibitors?
☐ No ☐ Yes → If yes, list_____

Previous TB Tx: ☐ No ☐Yes → for ☐ Infection ☐ Disease Year?_____ Where?_____

Medications/Duration_____ Past Resistance? ☐ No ☐ Yes → To: _____

Past Adverse Reactions to Anti-TB Medications? ☐ No ☐ Yes → If yes, list meds_____

Risk for TB Infection (check all that apply)

☐ Close Contact (current) ☐ HIV Infected ☐ Resident/ Employee in Congregate Living
☐ Injection Drug User ☐ Lived in High Prevalence Country ☐ Medically Under-served
☐ Homelessness ☐ Health Care Worker ☐ Locally Identified Risk Population

Risk for TB Disease (check all that apply)

☐ TB-Like Symptoms ☐ Children (age 0-4) exposed to High Risk Adult(s) ☐ Diabetes Mellitus
☐ Silicosis ☐ Malignancy ☐ End Stage Renal Disease (ESRD)
☐ Immunosuppressive Therapy ☐ Gastrectomy ☐ >10% Below Standard Weight for Height

DUE TO HIGH RATES OF FALSE POSITIVE RESULTS, TUBERCULIN SKIN TESTING IS DISCOURAGED IN LOW RISK POPULATIONS.

PPD Result #1
Date Given ____/____/____
Date Read ____/____/____
Induration _____mm
Offer HIV testing if PPD is positive.

PPD Result # 2
Date Given ____/____/____
Date Read ____/____/____
Induration _____mm
Offer HIV testing if PPD is positive.

Chest X-Ray Date: ____/____/____
☐ Initial Film ☐ Update Film
Patient Height_____
Patient Weight_____
Patient has history of Liver Disease? ☐ No ☐ Yes

IF CLOSE CONTACT TO A PULMONARY TB, PROVIDE NATURE OF EXPOSURE_____

Provide Index Case Name _____ and **SMEAR** Status: ☐ Positive ☐ Negative ☐ Unknown

TB Chemotherapy: ☐ **None** ☐ **Directly-Observed** ☐ **Self-Administered**

	Dose/Frequency	Start	Stop
INH	_____	____/____/____	____/____/____
RIF	_____	____/____/____	____/____/____
PZA	_____	____/____/____	____/____/____
EMB	_____	____/____/____	____/____/____

Drug	Dose/Frequency	Start	Stop
_____	_____	____/____/____	____/____/____
_____	_____	____/____/____	____/____/____
_____	_____	____/____/____	____/____/____
_____	_____	____/____/____	____/____/____

Drug Susceptibility Testing (M. tb isolates only) **Specimen Collection Date:** ____/____/____

Drug	**Sensitive**	**Resistant**	**Drug**	**Sensitive**	**Resistant**	**Drug**	**Sensitive**	**Resistant**
Isoniazid	☐	☐	Ethambutol	☐	☐	Ofloxacin	☐	☐
Rifampin	☐	☐	Streptomycin	☐	☐	Rifabutin	☐	☐
Pyrazinamide	☐	☐	Ethionamide	☐	☐	Capreomycin	☐	☐

Bacteriology: Check If No (+) Culture ☐ Collection Date of Last (+) M. tb Culture ____/____/____ Specimen Source_____

Collection Date of Latest Smear ____/____/____ Result: ☐ Positive ☐ Negative ☐ Pending Source_____

Collection Date of Latest Culture ____/____/____ Result: ☐ Positive ☐ Negative ☐ Pending Source_____

FOR BILLING ONLY: ☐ TB Suspect ☐ TB Case ☐ High Risk Contact ☐ MDR-TB Follow-up
☐ TB Classified Alien (Provide A# _____) ☐ HIV/TB Coinfected ☐ Other, explain:_____